

## Public health successes and frail health systems in Tanzania

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In mid-2015, close to the finish line of the Millennium Development Goals (MDGs), Tanzania has reason to be proud. As Hoviyeh Afnan-Holmes and colleagues note in their Countdown to 2015 case study,<sup>1</sup> Tanzania is on track to achieve MDG4: a two-thirds reduction in child mortality. The largest gains in survival have occurred between the years 2000 and 2012, when mortality for children between 1 and 59 months of age fell at an average rate of 8.5% per year. This reduction means that the country will not only attain the child survival MDG but might also reach more ambitious targets, such as the 2030 goal of 14 deaths per 1000 livebirths from A Promise Renewed.<sup>2</sup> Although some of this decrease in child mortality is attributable to important health-care efforts, such as the integrated management of childhood illness, most (around 39%) of the gains were achieved through public health and prevention programmes, such as immunisation and the use of insecticide-treated bednets.

By comparison, improvement in the health of neonates and their mothers has been lacklustre, with the pace of mortality reductions less than half that of children. Stillbirths remain too common, with nearly 50 000 babies in Tanzania stillborn every year. What explains the slow progress in reducing these deaths? A large part of the reason is poor quality of care in an overstretched health system. Clinics and health centres throughout the country are ill-equipped to provide the advanced care that some women and neonates need, such as treatment of postpartum haemorrhage and newborn resuscitation.<sup>3</sup> Afnan-Holmes and colleagues point to the dire shortages of doctors, nurses, and other highly skilled health workers in Tanzania, especially in rural areas, leaving the management of complex disorders in the hands of less trained staff. Yet government policies, such as the Primary Health Service Development Programme (MMAM in Swahili)<sup>4</sup> that promises a dispensary in every village and a health centre in every ward, continue to promote expansion of the number of facilities over investments in their quality.

Afnan-Holmes and colleagues analyse the policy environment for reproductive, maternal, and newborn health, noting that Tanzania's government, long a "donor darling", has had difficulty managing the explosion in donor interest and funding in health. The

government's laudable effort to coordinate several reproductive, maternal, newborn, and child health programmes—the One Plan—was not costed or made operational and therefore never fully implemented. Maternal and child health-care policies proliferated but were enacted unevenly, with strong implementation of child health interventions, only recent attention to neonates, and diminished attention to family planning or abortion. This situation is a missed opportunity to save lives, as the experience of Bangladesh shows that expansion of family planning on the one hand and reducing unsafe abortion on the other are essential to reduce maternal deaths.<sup>5</sup>

Afnan-Holmes and colleagues' analysis shows that national ownership and government accountability to the population continue to lag behind the government's stated commitment to health. Despite strong economic growth, donors still contribute US\$4 of every US\$10 spent on health in Tanzania. In 2010–11, Tanzanian government expenditures on health comprised only 11.9% of the government budget, which is below the 15% that Tanzania and peer countries promised to devote to health in the Abuja Declaration of 2001.<sup>6</sup> On the donor side, funding has been unpredictable and patchy, undermining the potential to promote lasting improvements in the health system, especially in the areas of health workforce and quality improvement that need a long lead time. This situation is discernible in the troubling data about disrespectful and abusive treatment of patients in Tanzanian facilities.<sup>7,8</sup> The alarming rates of poor treatment of women in particular reflects a health system that is weakly, if at all, accountable to its users. Improved accountability begins with strong central leadership, but crucially in Tanzania's decentralised health system, it depends on a strong, capable, and motivated district health management team.

Although Afnan-Holmes and colleagues' report covers substantial ground, several issues remain unexamined. For example, why have facility delivery rates in the country stagnated at roughly 50% over the past decade?<sup>9</sup> Although enhancement of women's agency in making health-care decisions is necessary, so is an improved understanding of the role of communities, of men and older women, and of traditional birth attendants.<sup>10</sup>

These actors have a powerful role in promoting or denying opportunities for effective care and therefore good health outcomes. Subnational analysis is needed to identify barriers related to geography and cultural and economic factors.<sup>11</sup> Other contextual issues, such as quality of roads, transport, and communication, were omitted from the analysis but surely play a large part in enabling access to care.

This detailed assessment of Tanzania's path to the MDGs draws attention to successes and detours. It shows how policy focus, global partnerships, and sustained implementation meaningfully improved the chance of survival for the country's children. It also proposes needed course corrections in newborn health and family planning—areas in which there are recent hopeful signs of government attention. To tackle the high mortality rate in mothers and neonates, new efforts to strengthen quality and responsiveness of health care will be needed. This investment is well worth making, not only for maternal and child health but also for the rising burden of non-communicable diseases and injuries facing Tanzania in the coming decades.

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